



New Jersey Office of the Attorney General

Division of Consumer Affairs

Board of Pharmacy

124 Halsey Street, 6th Floor, P.O. Box 45013

Newark, New Jersey 07101

(973) 504-6450

Requirements for Licensure

To be eligible to be licensed as a pharmacist in New Jersey an individual must:

- 1) be at least 18 years of age;
- 2) have graduated and received either a Bachelor of Science in pharmacy or a Doctor of Pharmacy degree from a college of pharmacy accredited by the American Council of Pharmaceutical Education (ACPE), **or** have graduated from a college of pharmacy program outside the U.S. and have obtained full certification from the Foreign Pharmacy Graduate Examination Committee (FPGEC);
- 3) take and pass the North American Pharmacist Licensure Examination (NAPLEX) and the Multistate Pharmacy Jurisprudence Examination (MPJE) for New Jersey;
- 4) have completed a 1,440-hour internship; and
- 5) undergo a criminal history background check.

Examination Requirements

- 1) In order to become licensed you must pass the NAPLEX and the MPJE for New Jersey;
- 2) Applicants must register online at the National Association of Boards of Pharmacy's (NABP's) Web site, www.nabp.net;
- 3) After you have completed item 2 above and the Board has processed your application for licensure, and your college or university has forwarded an official transcript showing the date you graduated and the degree conferred, you will receive an Authorization to Test (ATT) and instructions for scheduling a test appointment from the NABP;
- 4) The minimum passing score for NAPLEX is 75. The minimum passing score for the MPJE is 75. Any applicant failing to obtain a score of 75 on either examination will be required to repeat the examination. Applicants who fail must wait a minimum of 91 days to retake the NAPLEX and a minimum of 30 days to retake the MPJE

Note: Examination results will be mailed to the address provided on your application. **Do not call the Board office to obtain your examination scores.**

Foreign Graduates

- 1) The Board requires certification from the FPGEC for licensure, and completion of a 1,440-hour internship.
- 2) Foreign graduates are not eligible for licensure and are not eligible to apply for registration as an intern until they have received certification.
- 3) Once you have received your FPGEC certificate, send the Board a notarized copy, along with a letter requesting an intern application.

Internship Requirements

A candidate may comply with the 1,440-hour internship requirement in one of two ways:

- 1) by completion of a structured, college-accredited externship and clinical pharmacy clerkship program offered by an ACPE-accredited college of pharmacy. To further clarify, this means that the Board will accept up to 1,440 hours of practical experience

for applicants who are enrolled in a Doctor of Pharmacy program at an ACPE-accredited college of pharmacy; **or**

- 2) by completion of a 1,440-hour practical experience internship under the supervision of a Board-certified preceptor; such experience shall not be obtained in less than 34 weeks; each week of practical experience shall consist of no less than 15 hours and no more than 45 hours of actual service per week; the certified preceptor and applicant shall keep accurate records of the time spent in acquiring the practical experience and shall submit proof of such experience on specific forms supplied by the Board; credit will not be given for internship hours served prior to Board notification and approval of a preceptor.
- 3) **Foreign graduates are not eligible to apply for registration as an intern until they have received certification from the FPGE.**

Criminal History Background Check

- 1) N.J.S.A. 45:1-28 requires that all applicants undergo a criminal history background check as a condition for licensure.
- 2) The “Certification and Authorization Form for a Criminal History Background Check” is included as part of your application.
- 3) You must complete and submit this form as part of your application. Upon submission of this form, you will be forwarded information regarding the necessary steps to be taken for fingerprinting.
- 4) Criminal history reports generated for or by another agency or employer are **not** acceptable to satisfy this requirement.
- 5) Your license will not be issued until the complete results of the background check have been received and reviewed.
- 6) Reports of criminal history will require the applicant to submit additional documentation for review by the Board.



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Application Procedure

Please read the application, statutes, regulations and all instructions carefully. The statutes and regulations are available on the Board's Web site at www.njconsumeraffairs.gov/medical/pharmacy.htm. It is your responsibility to be aware of the licensing requirements and to provide all of the necessary documentation. (If you received this application by means other than directly from the Board or its official Web site, the application may be outdated or not an official version.)

Licensure by Reciprocity

An applicant who wishes to transfer his/her license into the State of New Jersey must have obtained initial licensure by examination, and that license must be in good standing. The applicant should complete the "NABP Preliminary Application for Transfer of Pharmaceutic Licensure" which can be found on the NABP's Web site, www.nabp.net. The following documents must be on file with the New Jersey Board of Pharmacy to be considered for licensure by reciprocity:

- 1) A completed, notarized application with a photograph attached;
- 2) The \$125 application fee in the form of a check or money order made payable to the "State of New Jersey";
- 3) A legible copy of your birth certificate. If the name on your application differs from that on your birth certificate, you must provide documentation of a legal name change (e.g. marriage certificate, divorce decree or court order);
- 4) An official transcript from an ACPE - accredited school or college of pharmacy or, if the applicant is a foreign graduate, certification from the FPGEC;
- 5) The Certification and Authorization Form for a Criminal History Background Check;
- 6) The official NABP application for a license transfer;
- 7) Verification that the applicant's initial licensure by examination is in good standing (the document must be sent directly to the Board from the state where the initial license was obtained);
- 8) Notification of a passing score on the MPJE exam for New Jersey; and
- 9) Verification that the applicant has engaged in the practice of pharmacy for a period of at least 1,500 hours within the last two years or has met the internship requirements set forth in N.J.A.C. 13:39 -2.6, within the two-year period immediately preceding the date of application.

Attach a clear, full-face passport-style photograph (2"x 2") of your head and shoulders, taken within the past six months.

A photograph is required with each application.

Do not use staples to attach the photograph.



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Application for Licensure as a Pharmacist by Means of Reciprocity

Date: _____

A nonrefundable application filing fee of \$125, in the form of a check or money order made out to the State of New Jersey, must be submitted with this application. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Board maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

Place of birth: _____
City State

1. Name ☐ Mr. _____
☐ Mrs. _____ (_____)
☐ Ms. _____
Last name First name Middle initial Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. Social Security Number

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

*Social Security Number: _____ - _____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

- a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;
- b. the Probation Division or any other agency responsible for child support enforcement, upon request; and
- c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

- ☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual payment of the loan. You will not be able to obtain a license or permit unless you provide the required documents concerning the plan for payment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

- a. Do you currently have a child-support obligation? ☐ Yes ☐ No
 - (1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No
 - (2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No
- b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No
- c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No
- d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

Applicant's name (please print)

Applicant's signature

Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or registration will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

For the purposes of these questions, the following phrases or words have the following meanings:

“Ability to practice as a pharmacist” is to be construed to include all of the following:

- The cognitive capacity to exercise the reasonable judgments of a pharmacist and to learn and keep abreast of professional developments; and
- The ability to communicate those judgments and related information to consumers and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and
- The physical capability to perform the duties of a pharmacist, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

“Chemical substance” is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

“Currently” does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, or within the previous two years.

“Illegal use of controlled dangerous substance” means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**? ☐ Yes ☐ No ☐ Not applicable
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable
- Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable
- Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? ☐ Yes ☐ No
- Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that “currently” is defined as “within the last two years.”) ☐ Yes ☐ No

If you answered “Yes” to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or permit should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

8. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

9. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

If “Yes,” provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

10. Do you currently hold, or have you ever held, a professional license, certificate or permit of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

If “Yes,” for each license, certificate or permit held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name.

		Last name	First name	Middle initial
Type of license, certificate or permit	Number	State or jurisdiction that issued the license, certificate or permit		Date issued/expired
Type of license, certificate or permit	Number	State or jurisdiction that issued the license, certificate or permit		Date issued/expired
Type of license, certificate or permit	Number	State or jurisdiction that issued the license, certificate or permit		Date issued/expired
Type of license, certificate or permit	Number	State or jurisdiction that issued the license, certificate or permit		Date issued/expired
Type of license, certificate or permit	Number	State or jurisdiction that issued the license, certificate or permit		Date issued/expired

11. Have you ever been disciplined or denied a professional license, certificate or permit of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

12. Have you ever had a professional license, certificate or permit of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Have you ever been named as a defendant in any litigation related to any prior practice as a pharmacist, or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Are you aware of any investigation pending against a professional license, certificate or permit issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to any prior practice as a pharmacist, or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

If the answer to any of the above questions, numbers 11 through 17, is “Yes,” provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education

1. What is the name and address of the high school you attended?

Name of high school

Street address

City

State

ZIP code

2. What years did you attend high school?

3. Did you graduate from high school? ☐ Yes ☐ No

If “Yes,” what was the date of your graduation?

Month

Year

If “No,” did you study to receive a G.E.D. certificate? ☐ Yes ☐ No

If “Yes,” please provide the name and address of the educational institution that issued your G.E.D. certificate and the date the certificate was issued.

Name of educational institution

Street address

City

State

ZIP code

Date certificate was issued

4. What is the name and address of the college or university you attended?

Name of college or university

Street address

City

State

ZIP code

Name of college or university

Street address

City

State

ZIP code

5. List all of the degrees that you have received from recognized colleges or universities. Please have each college or university forward to the Board the official transcript for each degree that you have earned.

Educational institution	Inclusive years	Degree, Diploma or Certificate	Major	Date granted

Experience

1. Please document your work experience below. Begin with your current or most recent experience in the pharmacy field and then work back in time, chronologically.

(a) Employer: _____

Address: _____

Street address

City

State

ZIP code

Telephone number: _____

(include area code)

Title of your position: _____ Hours per week: _____

Your major responsibilities (use additional sheets of paper if necessary): _____

From _____ to _____

Month

Year

Month

Year

Immediate supervisor's name and title: _____

(b) Employer: _____

Address: _____

Street address

City

State

ZIP code

Telephone number: _____

(include area code)

Title of your position: _____ Hours per week: _____

Your major responsibilities (use additional sheets of paper if necessary): _____

From _____ to _____

Month

Year

Month

Year

Immediate supervisor's name and title: _____

(c) Employer: _____

Address: _____

Street address

City

State

ZIP code

Telephone number: _____

(include area code)

Title of your position: _____ Hours per week: _____

Your major responsibilities (use additional sheets of paper if necessary): _____

From _____ to _____

Month

Year

Month

Year

Immediate supervisor's name and title: _____

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

} ss.

County of: _____

I, _____, in making this application to the Board of Pharmacy for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the Board of Pharmacy, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Board.

I further swear (or affirm) that I have read N.J.S.A. 45:14-40 et seq., together with the Rules and Regulations of the Board of Pharmacy, N.J.A.C. 13:39-1.1 et seq., and fully understand that in receiving licensure or certification from the Board, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board.

Signature of applicant

Sworn and subscribed to before me this _____

day of _____, _____
Month Year

Name of Notary Public (please print)

Signature of Notary Public

Affix Seal Here

Official Use Only☐ Dual License

License Type 1

Applicant's Number

License Type 2

Applicant's Number

**New Jersey Office of the Attorney General**

Division of Consumer Affairs

Board of Pharmacy

P.O. Box 45013

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Official Use Only☐ Resubmit

Board or Committee

**CERTIFICATION AND AUTHORIZATION FORM
FOR A CRIMINAL HISTORY BACKGROUND CHECK****Directions:** Answer all of the questions on this form.

1. Name ☐ Mr. _____ (_____)
☐ Mrs. _____ Last First Middle Maiden Name
☐ Ms.

2. Address _____
Street or P.O. Box City State ZIP code

3. Date of birth ____/____/____ Sex: ☐ Male ☐ Female
Month Day Year

4. Social Security number ____/____/____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No

If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history record background check process. No payment is necessary as of now.

If "Yes," please provide the following information and follow the instructions outlined below:

Board or committee requiring the fingerprinting

Month and year you were fingerprinted

If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs** (a background check conducted for the Department of Education, another state agency or another state does not apply) you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. **The fee for this service is \$25.30. (Beginning on March 19, 2012, this fee will be reduced to \$22.55.)** Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

CERTIFICATION

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature of applicant

Date



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Verification of State License

Section to be completed by the applicant.

To the applicant:

Complete this section of the form and mail the form to the licensing board of each state in which you are now or ever have been licensed to practice. You may duplicate this form if necessary.

Print or type full name in which license is held

License number

Date of birth

I hereby authorize the State of _____ to release all of the information in its files concerning my license and any actions or pending actions against my license to the Board of Pharmacy.

Signature

Date

Section to be completed by the state in which the license is held.

1. Is the license or certificate held by the above-named individual in good standing?
(If "No," please attach the details and certified copies of any orders.) ☐ Yes ☐ No
2. To your knowledge, has this individual ever been disciplined by your board or any other regulatory agency? (If "Yes," please attach the details and certified copies of any orders.) ☐ Yes ☐ No
3. Is there presently or has there been in the past a disciplinary proceeding against this licensee? ☐ Yes ☐ No
4. Date issued _____
5. Expiration date (if active) _____

If you have answered "No" to the first question above or "Yes" to the second or third questions, please attach detailed information and certified copies of any orders. Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure by means of reciprocity.

Name of board representative providing verification

Signature and title of board representative

Date

Return the completed form to:

Board of Pharmacy
P.O. Box 45013
Newark, NJ 07101

**Please affix
Board seal**



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Employment Verification Form

Section to be completed by the applicant.

Complete this section of the form and give it to your supervisor(s). You may duplicate this form if necessary.

Print or type full name in which license is held

License number

Date issued

State that issued the license

Section to be completed by supervisor or company representative.

Please complete the following:

Employer: _____

Postition: _____

Date(s) of employment: _____

Number of hours per week: _____

Name of person completing form

Title

Signature

Date

Telephone number (include are code)

Please mail this form directly to:

Board of Pharmacy
P.O. Box 45013
Newark, NJ 07101